WAISALE NATALEKOKO RAUQE (as administrator of the estate of VILIKESA RAUQE) v ATTORNEY-GENERAL OF FIJI

COURT OF APPEAL — CIVIL JURISDICTION

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REDDY P, KAPI and SHEPPARD JJA

20, 28 February 2003

10 [2003] FJCA 9

Negligence — contributory negligence — appeal against judgment of negligence on the part of the Plaintiff — whether evidence established contributory negligence — onus of contributory negligence lies on the Defendant — whether the deceased took the required breaks during their ascent — whether the learned judge was correct in finding negligence on the part of the Respondent — whether there was a basis in finding a failure to supervise the divers adequately.

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The Plaintiff as administrator of the Estate of Vilikesa Rauqe filed an appeal from the judgement of the High Court where the learned judge found that negligence had been
20 established in the death of Vilikesa Rauqe and Petty Officer Laiakini Tikoibau as a result of recovering an anchor during the diving operations. The judgment also established that there was contributory negligence on the part of the deceased thus damages should be reduced by two-thirds. The Appellant submitted that there should be no finding of contributory negligence and no reduction as to the amount of damages. The two-thirds reduction was also excessive as argued by the Appellant.

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Held — The onus of establishing contributory negligence lies on the Defendant. The evidence and the unchallenged finding by the judge of negligence establish negligence on the part of the Defendant. The answer submitted by counsel for Respondent is the failure of the two divers to follow instructions in taking breaks during their ascent. He relied
30 strongly on the evidence of Mr Druma who saw them ascending on the last dive without apparently stopping. But Dr Mua's evidence complicates matters. It does not show whether the divers were capable of making responsible decisions about how they should ascend. On the other hand, it seems possible that they were capable of making responsible decisions about how they should ascend because of the shortness of the period spent under water on the first dive. But then they were not admonished about their failure to signal the
35 time of their departure from the bottom. The evidence does not justify a finding of contributory negligence. The Respondent has not discharged the onus which rests upon it in this regard.

Appeal allowed.

Cases referred to

40 *Commonwealth v Verwayen* (1990) 170 CLR 394; 95 ALR 321; *Groves v Commonwealth* (1982) 150 CLR 113; 40 ALR 193; *Parker v Commonwealth* (1965) 112 CLR 295; [1965] ALR 1094, cited.

R. Matebalavu for the Appellant.

45 *N. Basawaiya* for the Respondent.

Reddy P, Kapi and Sheppard JJA. This is an appeal from a judgment of the High Court in an action brought by the plaintiff as administrator of the estate of Vilikesa Rauqe. It was brought both pursuant to the provisions of the Law Reform (Miscellaneous Provisions) (Death and Interest) Act (Cap 27) and the
50 Compensation to Relatives Act (Cap 29). The action under the latter Act was brought for the benefit of the deceased's mother and three sisters.

The issues dealt with by trial judge (Scott J) were whether or not the Plaintiff, now the Appellant, had established negligence and whether, if negligence were established, whether the damages which would be recoverable should be reduced by reason of contributory negligence on the part of the deceased, Vilikesa Rauqe. The deceased was an able seaman in the Fiji Naval Squadron to diving team. Also involved was Petty Officer Laiakini Tikoibau, who is also deceased. The two were engaged together in attempting to recover an anchor off Nayau Island. Both the deceased and the Petty Officer Tikoibau died as a consequence of what occurred during the diving operations. An action was also brought by his personal representatives but the hearings of the two cases did not take place at the same time nor were the hearings consolidated. However, we understand that the result of the present case will determine the outcome of the second case, both cases giving rise to similar questions.

When the hearing of the appeal began, counsel for the Attorney-General submitted that the judgment on liability which had been recovered was interlocutory and that leave to appeal from the judgment was required before the matter could proceed. We do not find it necessary to determine whether or not the judgment was interlocutory. In order to put the matter beyond doubt we grant leave, pursuant to s 12(2)(f) of the Court of Appeal Act (Cap 12). We do so because the judgment, although interlocutory in nature, had the effect of determining finally the question of liability between this parties.

In the result the learned judge found that negligence had been established but that, because of the contributory negligence of the deceased, the damages should be reduced by two-thirds. In the submission of counsel for the Appellant, there should either have been no finding of contributory negligence with the consequence that there should have been no reduction in the amount of the damages to be recovered or, if contributory negligence had been established, that the apportionment of two-thirds against the deceased was manifestly excessive with the consequence that this court should substitute what it considered to be an appropriate percentage.

The facts of the matter are set out in the judgment of the primary judge. The account of them which we are about to give largely comes from that judgment and from the evidence. As mentioned the two divers were endeavouring to recover an anchor which had been lost by another ship (the Kaunitoni) at an earlier time. His Lordship said that, after three dives during the course of which the anchor was located, the two divers left the water and rested. They then began to feel unwell, lapsed into unconsciousness and soon afterwards died. His Lordship said that the Plaintiff's case was that the Fiji Naval Squadron was negligent in the manner in which it conducted the diving operation. He also said that the Defendant denied negligence and asserted that the cause of the death was the failure of the two deceased divers to follow established diving procedures and the instructions given to them.

Brief reference is made by his Lordship to the evidence of the deceased's mother and father but this need not be referred to in this appeal because no issue arises in relation to it. The next witness was Dr Tukaha Mua. A report by him was submitted by consent. Dr Mua said that the divers, including the deceased, undertook a series of four dives (not three) to salvage the anchor. Following the fourth dive, the deceased developed pulmonary barotrauma which he described as involving pulmonary tissue damage, surgical emphysema and air embolism. He died soon afterwards.

Dr Mua said that decompression sickness had many other names. He instanced the bends, Caissons Disease and Raptures of the Deep. The doctor said that the condition was caused by air or nitrogen bubbles entering the circulation or central nervous system and blocking blood flow which would be followed by unconsciousness and cardiac arrest. Alternatively normal nerve transmission could be interrupted thus causing paralysis. He said that bubble formation was best illustrated by a bottle of lemonade. He said that the gas in a bottle of lemonade was dissolved in solution under high pressure. If that pressure were released very slowly (if the diver ascended slowly) one did not see the bubbles. However, if the bottle top were opened quickly (diver ascending without stopping) gas would bubble out of the lemonade "very clearly".

Dr Mua than related the facts as he understood them. Of course he could not give evidence about what actually happened and, in due course, it will be necessary to refer to the evidence of witnesses who did give evidence about what they observed at the time. He said that the first dive was 10 minutes in duration. He said that the depths of the dives and the actual times the deceased stayed at the bottom was not clearly stated but that changing an air cylinder after 10 minutes dive was unusual. If the depth were 50 ft, there was still enough air in the cylinder for another dive. He then dived for the second time. He said that the anchor was then found. The divers, or one of them, tied on the rope and the supervisor sent down another diver able seamen Druma. Mr Druma said that he saw both the divers ascending down without stopping. He reported this to the supervisor who "according to the inquest, warned them". He said that the supervisor should have stopped the deceased from further diving. Despite knowing that the deceased had broken the rules he was directed by the supervisor to dive two more times. He said on the third dive the deceased took down a shackle but was unable to secure it on to the anchor.

He said there were three unanswered questions; was the diver too weak or confused from decompression sickness and therefore unable to perform a straightforward job, was the current too strong, was he over exerting himself. He then dealt with the fourth dive and said that he took down a small shackle and rope but was still unable to secure it on to the anchor. He surfaced and 30 minutes later helped to resuscitate his diving partner.

Dr Mua said there was no doubt that the dive boat did not have any resuscitation equipment at all. He said that the basic resuscitation should include an oxyviva, airways, and an oxygen suction pump.

The doctor than expressed his opinions. He said that salvage operations were highly risky undertakings. They were performed by healthy, physically fit and experienced divers who were at all times required to observe very stringent rules. He said that mild decompression sickness was likened to alcoholic intoxication, hence the name raptures of the deep. Divers with this condition became carefree, weak and unable to perform straightforward jobs. They might take a few liberties or shortcuts as in coming in straight up from the bottom. The doctor also said that the supervisor in turn should be a very experienced diver who must be strict. He should recognise early danger signals and stop them from "escalating into full scale catastrophes". Dr Mua said that he was of the opinion that lack of skilled supervision had contributed to the death of the deceased.

Dr Mua's qualifications were not challenged but it may be noted that he is an experienced anaesthetist. He has been a senior lecturer at the Fiji School of Medicine for 11 years. He is the medical director of the recompression chamber in charge of all decompression treatments in Fiji for 18 years.

Dr Mua obviously relied on the transcript of the evidence given at the inquest into the two deaths. But that transcript does not fall part of the record in this case nor was it before the judge. It was not in fact intended although the judge expressed the view that it would not, in any event, have been admissible in evidence before him. It must have been from that transcript that Dr Mua concluded that there were four dives. The evidence to which we are about to refer suggests only three. Nothing turns on this.

Two further witnesses were called in the Appellant's case, the dive supervisor, warrant officer Vakatovolea and Mr Druma. His Lordship said that Mr Druma had told him that he was one of the three divers briefed by the supervisor on the day. They had been told the depth of the water and had also been told not to ascend at a speed which was greater than the ascending speed of smallest bubble which they emitted. Mr Druma said that the two divers had gone down and come up twice. They then went down for the third time and signalled that they had found the anchor. He himself than went down with a rope. He met the two divers coming up as he was going down. He said that they were "ascending at a speed". By the time he regained the surface, the other two were already out of the water and in the dive boat. He said that shortly thereafter they fell ill. He said that he did not say anything to anyone about the speedy ascent because the other two were much more experienced than he was.

His Lordship said that there was no dispute about the material cause of the death; it was decompression sickness. He said that it was not disputed that the principal cause of decompression sickness was ascending too rapidly from a deep dive. His Lordship said that, on the evidence so far summarised, there was no doubt in his mind that the two divers died because they ascended too rapidly, in other words because they failed to follow the proper procedures designed precisely for the avoidance of such accidents. He said that the two divers were experienced and fully trained. They had been fully briefed. He added that some portion of responsibility what occurred must rest with them and he went on to consider the appropriate amount or percentage by which any damages should be reduced.

It is important next to refer to the evidence of the supervisor. The evidence consists of a statement, a supplementary statement and oral evidence given before the primary judge. Relevant to the evidence is a record which was required to be kept by the supervisor and to which we shall refer in a little detail later on. In his original statement Petty Officer Vakatovolea said that on Friday 9 March 1990 at about 8 hours he boarded the MV Kaunitoni together with five naval officers under his leadership to dive for the anchor of the Kaunitoni which had been dropped some time in October 1989. He named the members of the team. They included the two deceased divers. Kaunitoni arrived at Nayau Island on 12 March 1990 at about 11 am. He said that the boat was not anchored at the Island but was "out in the sea". He left with his other four officers in the ship's boat with the diving gear to start diving for the anchor. The Kaunitoni remained about 26 m from where the diving operation was to take place. The witness said that on arrival at the site he called his officers and briefed them before the diving operation started.

The witness said that the two deceased were the two officers whom he had instructed to go diving. The witness said that he briefed the two deceased to dive in the sea for a period of 10 minutes and, while coming up to the surface, they should take a break for every 12 m. He said that the depth of the sea was known because in every diving duty, the divers used to carry a lifeline which is attached

to a safety float. This showed the reading of the depth of the sea. Before diving commenced he had already measured the depth of the sea by using the lifeline. The depth of the sea which he had measured was 75 ft, approximately 29.5 m. He said that the instruction he gave to the divers was to come up after diving and stop every 12 m.

He said that he was holding the safety line attached to the safety float which was then attached to the divers. If anything went wrong or they exceeded the time of diving given to them, he would pull the lifeline and the divers would feel it so that they would come up to the surface. When they first dived, they went to the bottom of the sea and saw the anchor. After securing the anchor they returned to the surface. He gave them 10 minutes before they recommenced diving. This was so that they could have a break. On the second dive, they took a rope with them. This was to be tethered to the anchor. After a break of 19 minutes both divers dived out into the sea after their gas tank was changed to a full tank of oxygen. It took them 8 minutes after they went into the sea, tethered the rope to the anchor and returned to the surface. They informed him that the rope was tethered to the anchor and that they would make a final check in the sea before pulling.

He gave them a 6 minutes break before their final dive. He changed their tanks to full gas tanks of oxygen. He said that they left for their third and final dive. In his supplementary statement he corrects this by saying that there were in fact four dives rather than three. We shall refer to this again when we come to the supplementary statement. He said that they made a check of the anchor and returned to the surface. It took them 20 minutes according to the time which he was "holding". He said that after diving he knew that they had followed the instructions which he had given to them. On arrival they came inside the ship's boat. They had a further break for 10 minutes.

He then signalled to the Kaunitoni to come towards them so that the anchor could be pulled from the sea. It took time for the Kaunitoni to come. The divers removed their diving gear except for their wet suits which they were still wearing. When they returned from their last dive the witness said that he did not check the gas tanks since he knew the diving was finished. While waiting for the Kaunitoni, the other ship's boat had already come to them. After 30 minutes of diving and waiting for the Kaunitoni he saw Tikoibau "feeling weak". When he talked to him he did not reply and he knew something was wrong. Artificial respiration was applied. At the same time he sent the other diver, Vilikesa, (that is Rauque) to go to the second ship's boat and get the oxy-viva from the Kaunitoni. When Vilikesa returned, he had the oxy-viva with him. It was then noticed that Vilikesa was feeling weak and suffering from the same condition as Tikoibau had suffered. The oxy-viva was applied to both men but they were feeling weak. They moved to the Kaunitoni. The ship's boat were hoisted to the Kaunitoni and left for the Lakeba Hospital. Both men died that evening.

In his second statement the witness said that he wanted to state that the two divers dived four times on the 12 March 1990. They used eight gas tanks altogether. He also mentioned the fact that his brother Able Seamen Druma also dived on that day. The witness also said that the police took his statement on 14 March 1990. He was then shocked and he could not recall the number of times the divers dived into the sea. He had not previously come across any accident of this kind. He said that the two divers were "expert" and had been diving for a number of years.

It is next necessary to refer to the record kept by Mr Vakatovolea. It is on folio 34 of a book or log which no doubt contains entries relating to a number of other dives. The record is a photostat copy of the original. It is difficult to read. We were informed that the original was not now available although it had apparently been produced at the inquest and at the naval inquiry which was subsequently held. It is dated 12 March 1990. It has six columns. The first is "Name," the second "Cyl Press" which is a reference to cylinder pressure, the third "Cyl Open" the fourth "Entered Water", the fifth "Left Surface" and the sixth "Left Bottom". There are some further entries on the right hand side of folio 34 but we have not thought it necessary to refer to them.

The names written under the Name column are difficult to read but one name which stands out is "Tiko". This appears three times, Tiko is no doubt a reference to Tikoivou … Seven lines are filled in; the last refers to Druma. The other three are not decipherable but probably refer to the other deceased Rauque.

As mentioned, the second column refers to cylinder pressure. It is filled in on each occasion. The column Cylinder Open, is not filled in. The column Entered Water is filled in as is the column "Left Surface". The column "Left Bottom" is not filled in. In order to make this record more understandable to readers of this judgment, we have appended a copy of the record to it. But the copy suffers from the imperfections that we have mentioned.

The fact that, omitting Druma from account, there are six entries and two divers would suggest that there were three dives and not four. The first two entries show that both divers entered the water at 12.05 pm and left the surface at 12.10 pm. Curiously, however, there is another time which appears above each of the entries, "12.10 pm". These are not the same time the first appearing to be 12.35 pm and the second 12.15 pm. The second entry into the water is noted at 12.10 pm which is the same time as the divers were said to have left the surface on the first dive. But the entries for the time of leaving the surface in the second dive are, so it would appear, 13–15 in each case. When one comes to the third dive, the times are not easy to read but the figures appear to be 13:06 or 13:86 (which could hardly be right because it will not represent a time) and 13:56. The entry in relation to Druma simply says across the columns "3 hours". The record does not suggest that the operation lasted 3 hours.

Mr Vakatovolea had the diving record available to him when he made his statements. He gave evidence before his Lordship and his evidence included evidence concerning the record. He identified the record and said that as a supervisor, he had a duty to keep the record of the dive. He said that the record showed the time the divers carried out diving. The record is in his handwriting. He said the columns headed "Entered water" and "Left Surface" meant the time when the divers entered the water and when they went down. The column "Left Bottom" meant the time they left the bottom. The witness agreed that the column was empty. No time was recorded. He said that this was the only record of the dive and that the dive had finished at 14:30 hours. We are unable to see the time 14:30 hours on the record. He said that the reason why the "Left Bottom" column was not filled in was that the divers did not signal to tell him that they were on their way up. He thus had no way of knowing when they had left the bottom and how long they had taken to reach the surface. That accounts for the blank column under the heading "left bottom".

There is no evidence given by the supervisor to the effect that he had admonished the divers on their return after the first dive for not signalling the time at which they began to ascend. In his evidence, Dr Mua suggests that the

divers were admonished after the first dive. This may have come from the inquest. But the transcript of the inquest was not before his Lordship. The same occurred in relation to the second dive, and, according to the record, in relation to the third dive. There is a question whether there were three or four dives. The record suggests only three. That was the supervisor's initial recollection. It is difficult, sitting on appeal, to give weight to the second statement he made in which he says that there were four dives but in the view that we take up the matter it is immaterial whether there were three or four. As will be seen the consequences are the same whichever is the case.

The only other evidence is the evidence of Mr Mosese Semi who was the commanding officer of the Kaunitoni, and Lieutenant Fox who was in charge of diving operations throughout Fiji. We have considered the evidence of the two witnesses but do not find it necessary to refer to the detail of it. The evidence is discussed in his Lordship's judgment in relation to the system which was in place. It should be said that it could not be suggested that the system which we shall later described in more detail was not adequate. Problem that has risen relates to the question whether that system was observed.

Against that background it is now possible to come to some conclusions. As earlier mentioned, the learned judge found negligence on the part of the Respondent. The basis of that finding was a failure to supervise the divers adequately. No challenge to that finding has been made. The issue with which we are concerned relates to contributory negligence. But, in order to deal with that matter, it is necessary to understand more fully how it was that the learned judge came to the conclusion that the Respondent was guilty of negligence. The negligence he found was negligence of supervisor for which the Respondent was vicariously liable. This, of course, is not a straightforward case of negligence committed by an employer or employer's servant. It is a case about negligence within one of the armed forces. In Australia, at least, it was not always clear that such an action lay. In *Parker v Commonwealth* (1965) 112 CLR 295, Windeyer J expressed reservations about whether such a cause of action would lie. But, at least in relation to activities of the services in peace time, these doubts were later resolved by the decision of the Full High Court in *Groves v Commonwealth* (1982) 150 CLR 113; see also *Commonwealth v Verwayen* (1990) 170 CLR 394. What has to be done in cases of this kind is to apply to them the principles which apply in the law relating to employment. It is the duty of an employer to take reasonable care for the safety of its employees. Part of that duty requires an employer to have in place a safe system of work and to provide safe means of access to that work. It is also the duty of an employer to ensure that the system it has devised is instituted and maintained. For this purpose it usually employs managers or supervisors to oversee the operations and undertake reasonable steps to ensure that the system is being observed by those employed to carry it out; see generally Fleming, *The Law of Torts*, 5th ed, 1977, pp 482–4.

The operation in question here was intrinsically hazardous. It involved divers having to descend to significant depths in the open sea in order to carry out their work. The principal dangers are described in the evidence of Dr Mua to which we have referred. A particular danger here was the risk of the divers suffering from the "bends" on their ascent. This was because of changes in pressure which would occur when a diver ascended from the comparatively high pressure of the sea at the depth at which he is working to the lower pressures which are present at or near the surface and, subsequently, in the atmosphere when he emerges from the water.

Of course divers have a duty to take reasonable care of their own safety. They are trained for the work. The dangers of the "bends" are emphasized and they are taught how to avoid the danger that is present.

Plainly the supervisor failed in his duty to see to it that the two divers were ascending from their dives in accordance with proper practice. They were required to stop each 12 m. The water was murky so that the supervisor could not see them once they had left the vessel. They did not signal when they left the bottom. So the question arises how was he to know whether or not they took the required breaks during their ascent. The supervisor knew or ought to have known that proper practice was not being carried out after the first dive. That was because he did not receive any signal when the divers left the bottom. On his own evidence he did not then remonstrate with the divers or instruct them that they must, in the interest of their own safety, send the signal at the time they left the bottom. Exactly the same thing happened on the second dive. No signal was sent. So he allowed the failure to observe the proper practice to continue. It was almost as if he did not expect them to send any signal. Perhaps the practice had fallen into disuse and it was left to divers to supervise themselves. In saying what we have, we have not overlooked what the supervisor apparently said at the inquest about his remonstrations. But even so it was Dr Mua's opinion that once there was one breach, the divers should have been stopped from further diving.

The great danger that always lurking in the background is the danger of the bends. "Raptures of the Deep" is another name for them. According to Dr Mua, divers affected in this way become "Carefree, weak and unable to perform straightforward jobs. They may take a few liberties or short cuts as in coming straight up". The evidence does not enable one to say whether in fact the divers were suffering from these problems. But the potential risk of divers in their situation suffering from them emphasizes the hazardous nature of the operation and makes it all more important that supervisors check the time of leaving the bottom and times of surfacing. If they are unable to do this — the supervisor was in that situation — he has a potential problem. But nothing was done about it.

The onus of establishing contributory negligence lies on the Defendant; see Fleming at 301. The evidence and the unchallenged finding by the judge of negligence establishes negligence on the part of the Defendant. What is the evidence of contributory negligence? The answer submitted for by counsel for Respondent is the failure of the two divers to follow instructions in taking breaks during their ascent. He relied strongly on the evidence of Mr Druma who saw them ascending on the last dive without apparently stopping. But Dr Mua's evidence complicates matters. We do not know whether the divers were capable of making responsible decisions about how they should ascend. On the other hand, it seems probable, because of the shortness of the period spent under water on the first dive that, at least during that dive, they were capable of behaving normally. But then they were not admonished about their failure to signal the time of their departure from the bottom. On this evidence can one be satisfied that they were at all responsible to the tragedy that be fell them after the last dive. We do not think one can. We think that the evidence does not justify a finding of contributory negligence. The Respondent has not discharged the onus which rests upon it in this regard.

It remains to mention one further matter. In his judgment the primary judge said that he did not think that it had been established that the lives could have been saved by having more equipment on the dive vessel. He referred in this respect particularly to the fact that the oxy-viva was not on the dive boat. There

was some discussion about this matter during the argument but it was inconclusive. In the circumstances we take the same view about it as did the primary judge.

For the reasons earlier given we set aside the learned judge's finding of contributory negligence. In the result there will be no reduction of the Appellant's damages.

The orders we make are:

(1) The appeal be allowed.
(2) The order made on 8 June 2000 be varied by omitting there from the words: "With the deceased's own contributory negligence being assessed at two-thirds".
(3) The Respondent pay the Appellant's costs of the appeal assessed in the sum of $1500.
(4) The Appellant's costs of the proceedings in the High Court be paid by the Respondent.
(5) The matter be remitted to the High Court for the assessment of damages.

Appeal allowed.